NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 | LICENSEE CODE: W I P B H 1 (2) | LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 (3) | LICENSE TYPE: 4 1 1 1 1 (4) | CAT (5)

CON'T 01 | REPORT SOURCE: L (6) | DOCKET NUMBER: 0 5 0 0 0 2 6 6 (7) | EVENT DATE: 1 1 0 3 8 2 (8) | REPORT DATE: 1 1 1 9 8 2 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 During normal operation on 10/15/82, while attempting to shift the yellow
03 instrument bus to its alternate supply, the bus was deenergized and a turbine
04 runback occurred. Also, as a result of the lost bus, containment pressure
05 channel 1PT-950 was deenergized for approximately one minute and reduced
06 the degree of redundancy required by TS 15.3.5-3 to zero. This is report-
07 able IAW TS 15.6.9.2.A.2. Both sets of containment spray logic were
08 operable at all times; one with 3/3, one with 2/3 channels available.

SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
E B (11)	A (12)	B (13)	Z Z Z Z Z Z (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 2	—	0 1 8	/	0 1	T	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
X (18)	H (19)	B (20)	Z (21)	0 0 0 1	Y (23)	N (24)	N (25)	W 1 2 0 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 Due to a misunderstanding between the operator and the control room, the
11 wrong instrument bus power supply was shifted and the normal supply to
12 the yellow gus was deenergized. Power was restored in approximately one
13 minute. Warning signs will be placed adjacent to the local supply breaker
14 stating the motor-generator should be unloaded prior to opening the breaker.

15 | FACILITY STATUS: E (28) | % POWER: 0 7 8 (29) | OTHER STATUS (30): N/A | METHOD OF DISCOVERY: A (31) | DISCOVERY DESCRIPTION (32): Operator observation

16 | ACTIVITY RELEASED: Z (33) | CONTENT OF RELEASE: Z (34) | AMOUNT OF ACTIVITY (35): N/A | LOCATION OF RELEASE (36): N/A

PERSONNEL EXPOSURES
17 | NUMBER: 0 0 0 (37) | TYPE: Z (38) | DESCRIPTION (39): N/A

PERSONNEL INJURIES
18 | NUMBER: 0 0 0 (40) | DESCRIPTION (41): N/A

LOSS OF OR DAMAGE TO FACILITY (43)
19 | TYPE: Z (42) | DESCRIPTION: N/A

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PUBLICITY
20 | ISSUED: N (44) | DESCRIPTION (45): N/A | NRC USE ONLY

NAME OF PREPARER: C. W. Fay PHONE: 414/277-2811

ATTACHMENT TO LICENSEE EVENT REPORT NO. 82-018/01T-0

Wisconsin Electric Power Company
Point Beach Nuclear Plant Unit 1
Docket No. 50-266

At 1831 hours on October 15, 1982, while investigating the cause of hot electrical wiring odor, the auxiliary building operator reported seeing signs of fire come out of the local supply breaker for 1GY04 motor-generator set. 1GY04 was supplying 1Y04, the Unit 1 yellow instrument bus at the time.

At 1833 hours, control was informed and the decision to shift the yellow bus to its alternate power supply was made. Due to a misunderstanding of which bus was to be shifted, 1Y03, the Unit 1 white instrument bus was shifted to its alternate power supply. Thinking that the correct instrument bus supply was shifted to the alternate supply, the auxiliary building operator opened the output breaker for 1GY04, and the 1Y04 bus was deenergized. A turbine runback occurred as a result of the deenergized instrument bus.

At 1834 hours, after the runback from 78% to 65%, 1Y04 was shifted to its alternate power supply. The unit returned to 78% power at 1950 hours on October 15, 1982.

An additional result of the lost instrument bus was the loss of 1PT-950, Unit 1 containment pressure channel. The loss of this channel for approximately one minute reduced the degree of redundancy required by Technical Specification 15.3.5-3 to zero. Both sets of containment spray logic were operable at all times; one with 3 out of 3, one with 2 out of 3 channels available.

The procedure used to shift the power supplies, OI-37, Shifting of Instrument Supply Bus Feeders, was not violated in this event. The event was caused by poor communications between the on-shift operators.

To prevent future occurrences of this type, warning signs will be posted adjacent to the local supply breaker stating that the motor-generator should be unloaded prior to opening breakers. Proper communications will also be discussed among the Operations personnel during upcoming training to stress its importance.

This event is reportable in accordance with Technical Specification 15.6.9.2.A.2.